130

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with

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CONTENTS

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CHILDREN'S BUREAU
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UNITED STATES DEPARTMENT OF LABOR
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THE CHILD — MONTHLY NEWS SUMMARY

Volume 2, Number 6 December 1937

FOREIGN LEGISLATION

MATERNAL AND CHILD-WELFARE LEGISLATION IN SWEDEN

Several new laws enacted in Sweden, which become effective on January 1, 1938, provide for a national system of maternal and child-health work and for Government aid to mothers during pregnancy and at childbirth, to unmarried mothers, and to fatherless or motherless children and children whose parents are incapacitated for work.

A preventive program is to be developed through maternal and child-health centers giving free service, the establishment of which is authorized in counties and cities under instructions to be issued by the National Department of health. Government aid will be given in the form of a lump-sum grant not to exceed one-half of the cost of establishing and equipping the health centers and also in the form of subsidies for the salary and travel expenses of physicians, nurses, and midwives. The preventive maternal and child-health work will be under the supervision of the National Department of Health, which will also have charge of the distribution of funds.

Maternity benefits are provided on a liberalized basis under a second law, which replaces a law of 1931. The new law provides for benefits of 75 kronor. (A kronor was equal to 25.55 cents in international exchange in October 1937.) Women are eligible who do not belong to any recognized sickness-insurance organization and whose taxable income (joint income of husband and wife if they live together) does not exceed 3,000 kronor a year. This is more than the average annual income of industrial workers in Sweden, according to the latest available figures, and more than twice the average annual income of agricultural workers. Under the old law the income limit was 500 kronor, and the benefits amounted to about one-fourth to two-thirds of those provided for under the new law. Under a separate law the minimum maternity benefits paid to women insured by the sickness-insurance organizations are to be almost doubled. The insurance organizations are reimbursed for this outlay by the National Treasury.

Aid from public funds for needy expectant mothers and mothers recently confined is provided by another new law. This aid may be given in one or more remittances, in amounts varying according to need, but the total per case must not exceed 300 kronor. This law is to be administered by maternity-aid boards, which are to be established throughout the country, in cooperation with the child-welfare boards.

Pensions for fatherless or motherless children and children under 16 whose parents are permanently incapacitated for work are to be paid from public funds under still another law. The amount of the pension varies according to locality and number and age of children.

Payments to unmarried mothers for the maintenance of children under 16 are to be made from public funds, according to another law, if the father responsible for the child's support fails to make the payment. The amount varies according to cost of living in the locality, age of the child, number of children in the family, and income

of the mother. The local child-welfare board, which makes the payment and is reimbursed by the National Treasury and the commune, must see that the money is used for the child.

Except for the preventive maternal and child-health work, the benefits of these new laws apply only to Swedish citizens residing in Sweden. These benefits may be extended through reciprocal treaties with other countries, however, to citizens of those countries residing in Sweden. *Tidskrift för Barnavård och Ungdomsskydd, Stockholm, Nos. 4 and 5, 1937.*

NEW LEGISLATION IN DENMARK

Law regarding pregnancy

A law of Denmark (No. 163, May 18, 1937) legalizes therapeutic abortion under stated conditions. Officially established clinics to provide instruction in sex hygiene and in prenatal care must be available before April 1, 1938, when the law comes into force. In Copenhagen the establishment of these clinics devolves on the municipal administration; elsewhere, on the provincial authorities. The State treasury will refund to the communes half of the expenditures incurred. These clinics will operate in cooperation with the communal social-welfare committees established under the Social-Welfare Law of 1933. Pregnancy must not be interrupted without a certificate from one of these officially established clinics that the woman has been advised of the support available if she completes her pregnancy and instructed as to the dangers and possible consequences of interrupting pregnancy. A certificate may be dispensed with in cases where the life or health of a pregnant woman is endangered by disease. In the case of a minor, the consent of parent or guardian is necessary for the interruption of pregnancy.

The law provides that a woman who interrupts her own pregnancy, even if the conditions laid down for the legal interruption of pregnancy are fulfilled, shall be punished by detention for not more than 3 months. A person who without being an authorized doctor, interrupts pregnancy or gives assistance for the purpose shall be punished by imprisonment not exceeding 4 years, 8 years, or 12 years, according to the gravity of the offense. *League of Nations, C.Q.S./F.E./C.I./22. Legislative and Administrative Series, No. 20, Geneva, October 27, 1937; Lovtidenden, Copenhagen, A. No. 21, May 31, 1937.*

Legitimacy and maintenance laws

The conditions under which a child is to be considered legitimate are defined in a Law of Denmark enacted May 22, 1937 (Law No. 132), which becomes effective January 1, 1938. This new law replaces earlier statutes on the subject. *League of Nations, C.Q.S./F.E./C.I./21. Legislative and Administrative Series, No. 21, Geneva, October 27, 1937.*

Law No. 133, enacted May 7, 1937, is concerned with the contributions for maintenance required in cases of separation or divorce, or by judgment, for the present or former husband or wife, child, adoptive child or step-child, or for a woman made pregnant out of wedlock. This law also becomes effective on January 1, 1938. *League of Nations, C.Q.S./F.E./C.I./20, Legislative and Administrative Series, No. 19, Geneva, October 27, 1937.*

HIGH COUNCIL FOR CHILD WELFARE IN FRANCE

By a decree of the President of the French Republic dated September 30, 1937, a High Council for Child Welfare was established in France with the Minister of Public Health serving as chairman.

The duty of the Council is to coordinate public and private services, organizations, and institutions concerned with the protection of children; to ensure contact between the departments of the various ministries concerned with child welfare and the competent committees of the League of Nations; and to study questions of child welfare.

The Council consists of 35 members, of whom the Minister of Public Health chooses 10 members to form a permanent section. A permanent secretariat is set up under a permanent Secretary-General, who may be a woman. The permanent secretariat prepares the work of the High Council and the permanent section and sees that the decisions of the High Council are carried out. *Journal Officiel, Paris, October 1, 1937, p. 11,152.*

THE SOCIAL SECURITY PROGRAM FOR CHILDREN

DEVELOPMENT OF MEDICAL SERVICE FOR DEPENDENT CHILDREN IN SULLIVAN COUNTY, INDIANA

BY LOUISE GRIFFIN, SUPERVISOR, CHILD-WELFARE SERVICES,
AND FAE LOGAN, CHILD-WELFARE WORKER, INDIANA DEPARTMENT OF PUBLIC WELFARE

Ed. note.--Under the reorganization of State and county public-welfare activities in Indiana a plan is being developed for constructive child-welfare services in all counties in the State. Since 1881 provision for foster care for dependent and neglected children has been a responsibility of county units. The improvement of methods for care of dependent wards of the county is, therefore, a major problem of the new child-welfare program of the State. The following article outlines the initiation of medical services in one county as a definite part of public foster care. This is one of the counties to which a child-welfare worker has been made available by the State Department of Public Welfare through the use of Federal social-security funds. Similar demonstrations of constructive child-welfare services adapted to local needs and resources have been undertaken in several other counties. E.O.L.

A special child-welfare worker began work in Sullivan County in November 1936, taking over responsibility for case-work services for children who were wards of the county department of public welfare and other neglect and behavior-problem cases. After a few months it was possible to begin to plan for regular medical care for the 60 children who were under care of the department. The 44 children who were wards before the county child-welfare worker began her services had never had regular medical care. No medical records of any sort had been kept, so that it was not possible to know whether a child had had a thorough physical examination or what care a child had received. In many cases of foster-home placement the child had undoubtedly been given a rather thorough examination, but since there were no records, there was no information available to be used in follow-up work.

Early in the planning of the medical program Dr. Howard B. Mettel, Chief of the State Bureau of Maternal and Child Health, was consulted as to the best method of presenting to the Sullivan County Medical Association the medical needs of the children under care. Dr. Mettel was very helpful in suggesting methods for presenting the need. It was thought that after a year the medical service might be reviewed and at that time further steps might be planned.

The first step taken toward planning a medical program for child wards of the county was to present the need at a meeting of the Sullivan County Children's Committee, an unofficial advisory group. The conclusion reached at that meeting was that a plan for medical services for dependent children was badly needed, but that before any program was considered the county medical association should be consulted.

The proposal for regular medical service for children under care of the county department was then presented to the policy-forming committee of the county medical association--the reference committee. The proposition made to this committee was not that the doctors should give free service, but that they should help to work out a plan for fair compensation for the service needed. The county budget for the care of children, including board and clothing, had been prepared on a per capita basis and was submitted to the doctors for their guidance. After thorough discussion the doctors undertook to work out a schedule for medical services. The reference committee then reported to the county medical association and a program was suggested.

The State Supervisor of Child-Welfare Services discussed the welfare program in Sullivan County, as well as the State program, with the Secretary of the Indiana Medical Association and was assured of his interest and future efforts in helping county departments to develop good medical care for their dependent children. He also made suggestions which will be most helpful in Jay County, the second child-welfare demonstration area.

After receiving the report of the medical reference committee, the county children's committee voted to recommend to the board of the county department of public welfare, which has the authority to establish policies and make decisions, that a general physical examination, including a Wassermann test and dental examination, be given to each

child in care, and that other tests and follow-up treatment be given according to the doctor's recommendations. A plan was developed for assuring for each child continuity of medical service from the same doctor. The importance of keeping the medical records up to date was also discussed.

The recommendations of the children's committee were then presented to the county board of public welfare, together with the recommendations of the county medical association. The board members did not authorize general physical examinations of all children then under care, but they did agree that a general examination should be given in all new cases and that all children under care should have medical treatment when needed.

It was also agreed that all children under care should have regular dental treatment.

A number of children were found to be in definite need of medical attention and were taken to a doctor for general examination. The results have been recorded on the medical record forms. In many cases it has been impossible to get complete information about the child's early physical history because of lack of previous records.

All medical forms used by the county departments are provided by the Children's Division of the State Department of Public Welfare. Objections to what seemed highly detailed forms decreased when it was found that the examination did not take as much time as was anticipated, and in each instance the doctor has asked to keep a copy of the record for his own files.

The doctors have shown very real interest in individual children and in the whole child-welfare program as children have been taken to them. Few plans have been made for special care, such as operations, since the regular medical program was outlined, but in these cases the doctors have made moderate charges.

County funds provide numerous ways of giving medical care to children. The county welfare fund has two items, "Assistance to children in custody of individuals" and "Assistance to children in custody of institutions," which provide the day-by-day care, including routine medical care, for children in foster homes, particularly boarding homes, and in institutions. The maximum amount for this care is limited by law to 75 cents a day. Two additional items in the welfare fund, "Assistance to crippled children" and "Assistance to sick children other than crippled," provide special types of care, including hospitalization.

The plan for medical care which was prepared by the reference committee of the county medical association included the following provisions:

Complete physical examination of children received for care with report of all defects and recommendations as to corrections or treatment needed.

For children under 2 year of age: a check-up every 3 months; oftener if the child is not progressing properly.

For children over 2 years of age: a check-up every 6 months.

Medical and surgical care when and as needed.

Free choice of doctors.

Primary examination:

Case history, family records, past medical history of child to be prepared by the county child-welfare worker.

Physical examination to be made by physician.

Laboratory tests by hospital laboratory or by a physician equipped to make them.

Follow-up: Based on needs shown by physical examination to be carried out by local physicians as far as possible, if the county welfare department can pay for such care.

Physical check-up to be made by the physician who made the original examination if possible.

Reports:

Original examination records made out in duplicate; one for the files of the county welfare department and one retained in the file of the examiner.

Record of physical check-up made out in duplicate; one sent to the county welfare department, the other added to examiner's file.

Record of any operation, treatment of illness, or other medical care given to a ward by the physician, made out in duplicate; one copy sent to the county welfare department, the other added to the examiner's file.

All records and report blanks to be furnished by the State Welfare Department.

STATE AND LOCAL PERSONNEL AND SERVICES

Analysis of 1938 Maternal and Child-Health Budgets, Including Federal, State, and Local Funds[1]

BY CLARA E. HAYES, M.D.,
MEDICAL OFFICER, CHILDREN'S BUREAU

Forty-one States, the District of Columbia, Hawaii, and Alaska have separate divisions of maternal and child health whose directors are responsible directly to the State health officers. In seven States the bureau of maternal and child health is under or a part of another division of the State department of health.

Forty States and the District of Columbia have full-time directors of maternal and child health. Eight States, Alaska, and Hawaii have part-time directors. Thirteen States provide for 14 full-time assistant directors. In some States the directors give part of their time to crippled children's services. All directors and assistant directors are physicians, most of whom have had special training in pediatrics or obstetrics and special training or experience in public-health work.

Medical Services and Education

The full-time medical personnel provided for all State staffs includes 41 directors, 14 assistant directors, 57 other physicians (of whom a majority are obstetricians or pediatricians), 2 tuberculosis specialists, 2 immunologists, 1 psychologist, 1 mental hygienist, 1 otologist, and 1 ophthalmologist. The amount allotted from Federal and State salary and travel funds for full-time medical personnel is $549,235.78. The part-time medical personnel on State staffs includes 10 part-time directors, 57 clinical assistants in obstetrics or pediatrics, 4 tuberculosis specialists, and 2 directors of local health administration. The amount budgeted for salary and travel of part-time medical personnel is $104,694.96.

The State plans provide also for medical personnel on local staffs. Full-time medical personnel on local staffs includes 2 city directors of maternal and child health and 12 clinical assistants in obstetrics or pediatrics, with a salary and travel allotment amounting to $61,555 from Federal, State, or local funds. Part-time medical personnel on local staffs includes 16 clinical assistants in obstetrics or pediatrics, 1 director and 2 assistant directors of school-health services, and 1 school physician, with a salary and travel allotment of $22,940. Contributions to 172 local health officers' and 7 local assistant health officers' salary and travel amount to $256,400.56, almost entirely from State and local funds included in the maternal and child-health budget for matching Federal allotments.

The total amount budgeted under State maternal and child-health plans for salary and travel of all State and local medical personnel, both full-time and part-time, is $994,826.30.

Sums budgeted for postgraduate medical courses include $16,109.10 for medical trainees and $133,570.55 for postgraduate lectures or courses given by special lecturers in obstetrics or pediatrics to local physicians, making a total of $149,679.65 for medical education.

The provision for medical services by local physicians is shown below:

Prenatal, postnatal, infant, and preschool conferences, and immunization and mental hygiene	$222,635.56
Medical inspection of school children	37,705.75
Consultant obstetricians, pediatricians, and otolaryngologists	25,250.00
Physical examination of midwives	1,350.00
Total for local medical services	286,941.31

Public Health Nursing Services and Education

Twenty States have separate divisions of public-health nursing. In 31 States the nursing service is under other divisions of the department of health: 22 under maternal and child-health divisions and 9 under other divisions. Twenty-eight States include in their plans nursing delivery service in the patient's home.

On State staffs there are 370 full-time nurses with a salary and travel allotment from

[1] Only those State and local funds which were designated by the States as matching funds for the Federal allotments are included in this budget analysis. The figures are subject to change through budget revision, amendments, and supplements.

Federal and State funds amounting to $949,714.23 and 297 part-time nurses with an allotment of $318,141. On local staffs there are 2,120 local nurses giving all or part of their time to maternal and child-health work, for whom there is budgeted from Federal, State, or local funds $2,661,065.05. The total amount provided for salary and travel for the 2,787 State and local nurses, both full-time and part-time, is $3,898,920.28.

The plans of 28 States include grants for nurse trainees, totaling $97,951.30. Nine States budget $9,850 for public health nursing and maternity institutes. In addition, $10,710 is spent for other forms of nursing education in maternal or child health, making a total for nursing education and training of $118,511.30.

The total amount budgeted for all nursing services and education is $4,017,431.58.

Dental Services and Education

The dental unit is a major division of the health department in seven States. One of these, however, includes no item for dental service in its maternal and child-health budget. In six States the dental unit is a bureau under one of the divisions of the health department. In 21 States where there is no dental unit, dental service is rendered through the maternal and child-health division. Seventeen States in addition to the one mentioned above include no dental service in their budgets.

Twenty-five State plans provide for 48 full-time dentists on State staffs; 10 States provide for 37 full-time dental hygienists; and 1 State has a teacher-supervisor of dental hygiene. The amount budgeted from Federal and State funds for salary and travel for the full-time dental personnel on State staffs is $264,509. Nine States allot $18,437.38 for 14 part-time dentists on State staffs.

Two States provide for 3 full-time dentists on local staffs, and 4 States provide for 7 full-time dental hygienists with a total salary and travel allotment of $14,939.48. Seven States provide 41 part-time dentists for local staffs, with a salary and travel allotment of $41,860. The total amount budgeted from Federal, State, and local funds for salary and travel of State and local dental staffs, full-time and part-time, is $339,145.86.

Eight States budgeted $7,658 for dental health education and training. For local dental services at clinics, $43,666.06 was budgeted from Federal, State, and local funds, making a total of $390,469.92 for all dental service and education.

Health Education Services

At least five States have divisions of health education. Two others presumably have such divisions, but the information received is indefinite. In three States there are bureaus of health education under one of the major divisions of the health department. In 16 States the health-education work is planned through other bureaus. Twenty-five States provide no funds for this service in their maternal and child-health budgets.

On State staffs 15 States provide for 18 full-time health educators with a salary and travel allotment of $62,820.64. Eleven States provide for 10 part-time health educators with a salary and travel allotment of $15,490. The total amount budgeted for salary and travel of health-education staff is $78,310.64.

Nutrition Services

Twenty State budgets include $96,741.67 for 33 full-time nutritionists, and one State budget includes $2,000 for a part-time nutritionist. Two of these States provide $6,200 for 3 full-time nutritionists on local staffs. Thirty States have budgeted no maternal and child-health funds directly for nutrition work. The total amount budgeted from Federal, State, and local funds for salary and travel for nutrition staff is $104,941.67.

Recapitulation

The allocation of funds under 1938 State plans for maternal and child-health professional services of various types may be recapitulated as follows:

Medical service and education .	$1,431,447.26
Nursing service and education .	4,017,431.58
Dental service and education. .	390,469.92
Health-education service. . . .	78,310.64
Nutrition service	104,941.67
Total.	6,022,601.07

The total amount provided for local medical and dental services is $830,607.37.

The total amount provided for medical, dental, and nursing education and training is $296,548.95.

NEWS NOTES

Public Health Nursing Advisory Committee

A Special Advisory Committee on Public-Health Nursing has been appointed to serve in a consultative capacity on aspects of the public health nursing program of the Children's Bureau as it relates to maternal and child-health services and services for crippled children carried on in the States under the Social Security Act.

The chairman of the committee is Katharine Tucker, Director of the Department of Nursing Education, University of Pennsylvania. As members of the General Advisory Committee, Amelia Grant of the National Organization for Public Health Nursing and Hazel Corbin, General Director of the Maternity Center Association, become ex-officio members of the new committee. Other committee members are:

Shirley C. Titus, School of Nursing, Vanderbilt University, Nashville, Tenn.

Elizabeth G. Fox, Executive Director, New Haven Visiting Nurse Association.

Marian W. Sheahan, Director, Division of Public Health Nursing, New York State Department of Health.

Mrs. Abbie Weaver, Director, Public Health Nursing Service, Department of Public Health, Atlanta, Ga.

Florence L. Phenix, Assistant Director, Crippled Children's Division, Department of Public Instruction, Madison, Wis.

Winifred Rand, Merrill-Palmer School, Detroit, Mich.

* * * * *

Dental Advisory Committee

A Special Advisory Committee on Dental Health has been appointed for the Children's Bureau and will consider problems arising in connection with the dental programs being carried on in the States under the Social Security Act. The new committee held its first meeting in Washington on November 16, 1937.

The following persons have been appointed as members of the committee:

Guy Millberry, D.D.S., Chairman, Dean of the University of California College of Dentistry.

C. Willard Camalier, D.D.S., President, American Dental Association, Washington, D.C.

Leroy M.S. Miner, D.M.D., M.D., Dean, Harvard University Dental School, Boston, Mass.

Lon W. Morrey, D.D.S., Supervisor, Bureau of Public Relations, American Dental Association, Chicago, Ill.

Harvey J. Burkhart, D.D.S., Director, Rochester Dental Dispensary.

William N. Hodgkin, D.D.S., Vice President, National Association of Dental Examiners, Warrenton, Va.

Gerald D. Timmons, D.D.S., American Association of Dental Schools, Indianapolis, Ind.

Bert G. Anderson, D.D.S., Assistant Professor of Surgery, Yale University School of Medicine.

* * * * *

Poll on Federal aid to mothers at childbirth

A nation-wide survey by the American Institute of Public Opinion, the results of which were made public in November 1937, indicates that a large-scale Federal program for aid to mothers would receive general support. The question asked was: "Should the Federal Government aid State and local governments in providing medical care for mothers at childbirth?" Eighty-one percent of the persons who replied to the poll said, "Yes"; nineteen percent replied, "No."

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Cerebral-palsy project in New Jersey

Under the direction of the New Jersey Crippled Children's Commission a special committee was appointed in the fall of 1936 to investigate and draw up a plan for the care and treatment of children suffering from cerebral palsy. In a series of seven clinics 65 children were examined. In 85 percent of the cases the findings indicated that the child would receive benefit from treatment.

As part of the project a demonstration unit for treatment was established in Babbitt Hospital, Vineland, N.J., in December 1936. The progress made by the patients during the first 6 months and the methods of treatment used are described by Winthrop M. Phelps, M.D., Medical Director of Babbitt Hospital, in an article, "The New Jersey State Project for Cerebral Palsy," in the *Journal of the Medical Society of New Jersey* for September 1937.

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MATERNAL, INFANT, AND CHILD HEALTH

SCHOOL PROGRAMS OF MOUTH HYGIENE SURVEYED BY CLEVELAND CHILD HEALTH ASSOCIATION

In June 1936 the Cleveland Child Health Association undertook to obtain information as to what was being done to solve the problem of mouth hygiene among the school children of the United States. It has now published the first of a series of reports based on replies from 213 cities. In the first report data are given for the 13 cities having a population exceeding 500,000 according to the United States Census of 1930.

All 13 of these cities have some type of dental program for school children, the report shows. In the majority of the cities the school mouth-hygiene program is administered by the Department of Health exclusively or in cooperation with the school authorities or some private foundation.

It was found that in 9 of the cities definite provision is made for dental health education in classrooms. The percentage of children needing dental attention varied from 98 percent to 71 percent in the 9 cities reporting on this point, according to the type of examination given, the personnel employed, and the grades examined.

In 11 cities responsibility for referring children for service and making necessary social ratings is invested in the school nurse. In most instances following the dental examination notices are sent to parents informing them that defects have been found and suggesting that the child be taken to the family dentist.

All the cities make some provision for dental care, although none of them is able to meet completely the need for free service. In 10 cities clinic services are provided by the health department, and in the other 3 by the school department or board of education. Hospital dental clinics assume part of the burden in 8 cities and private philanthropic organizations and foundations in 9 cities.

Provision for part-pay or low-cost dentistry was found to be more limited. Two cities (Buffalo and Pittsburgh) recorded no facilities for such care. Dental schools serve a limited number of patients (mainly adults) in 8 of the cities. Hospital dental clinics usually arrange for reduced fees and are the only source of part-pay service in some cities. Four of the cities (Los Angeles, San Francisco, Chicago, and New York) reported clinics to provide low-cost dentistry established by philanthropic organizations or groups of dentists. Some of these clinics were supported almost entirely by fees collected from the patients. Four other cities (Detroit, St. Louis, New York, and Cleveland) have established, through the cooperation of the dental society and local social agencies, plans by which clients may be referred to cooperating neighborhood dentists for service at reduced fees after social rating has been made by an accepted agency.

An attempt has been made to learn the extent of dental facilities for preschool children in these cities. Four cities stated that they had no organized program for preschool children; four mentioned that they reached some preschool children through the summer round-up examinations. Clinic services that include preschool children were reported by Los Angeles County, San Francisco, Chicago, Baltimore, Boston, New York, and Cleveland. In most of these, however, the number of preschool children reached by the clinics is very small. *A Survey of Mouth Hygiene Programs for School Children: Section 1, Thirteen Largest Cities of the United States, by the Cleveland Child Health Association, 1001 Huron Road, Cleveland, 1937. 201 pp. Mimeographed.*

BOOK AND PERIODICAL NOTES

SOCIAL BEHAVIOR AND CHILD PERSONALITY; an exploratory study of some roots of sympathy, by Lois Barclay Murphy. Columbia University Press, New York, 1937. 344 pp.

This study was sponsored by the Josiah Macy, Jr., Foundation and carried on at the Child Development Institute of Teachers College, Columbia University.

The focal point of the study is the analysis of children's responses to distress in other children as observed from the behavior of children in

nursery school. Part 1 is concerned with the cultural setting, part 2 with an analysis of sympathetic behavior in nursery-school children from various angles, and part 3 with synthesis and interpretation of the findings. In the final chapter the author develops a theory of the development of sympathy.

THE RELATION OF ACCELERATED, NORMAL, AND RETARDED PUBERTY TO THE HEIGHT AND WEIGHT OF SCHOOL CHILDREN, by Herman G. Richey. Monographs of Society for Research in Child Development, vol. 2, no. 1, Serial No. 8. National Research Council, Washington, 1937. 67 pp.

This paper is concerned with the relation of precocious, normal, and retarded physiological maturation to the heights and weights of boys and girls at all ages from 6 through 17-18 years. The study indicates that:

(1) Girls and boys who mature physiologically before 13 years are on the average heavier and taller at each age than those maturing between 13 and 14, or after 14 years.

(2) Growth as measured by height and weight is slightly accelerated before puberty, but the decline in the rate after puberty is more marked than the earlier acceleration.

(3) In addition, there are great differences in the heights and weights of the different maturity groups and also in the relation of weight to height.

The author concludes that no statement concerning overweight or underweight should be made without considering the factor of maturation.

TWENTY-FIVE YEARS OF HEALTH PROGRESS, by Louis I. Dublin, Ph.D., and Alfred J. Lotka, D.Sc. Metropolitan Life Insurance Co., New York, 1937. 611 pp.

This volume, addressed to health officers, physicians, sociologists, life-insurance officials, and others interested in the health and welfare of the wage-earning population, records the progress of public health during a quarter of a century (1911-35) as indicated by the mortality experience of the industrial policy-holders of the Metropolitan Life Insurance Company and by parallel data from general population and mortality statistics. The several chapters are devoted to an analysis of trends in general mortality, to the longevity through the quarter century, and to the trends and the factors underlying mortality from the principal diseases of childhood, from tuberculosis, influenza and pneumonia, cancer, the principal cardiovascular-renal diseases, diabetes, diseases of the puerperal state, other diseases of special interest, such as acute poliomyelitis and syphilis, and mortality from external causes including suicide, homicide, and accidental deaths. Each chapter contains many valuable statistical tables and charts.

The chapter on the principal communicable diseases of childhood and the chapter on the diseases of the puerperal state will be of particular interest to workers in the field of maternal and child health. The following paragraph on maternal mortality is particularly pertinent at this time:

> Taking into consideration the information available, it can be stated that maternal mortality is actually somewhat lower today than it was earlier in the century. The improvement, however, is at best slight and cannot, in any case, be considered adequate in the light of the advances made in medical science and practice during the same period. That thousands of American mothers are still needlessly being sacrificed each year is apparent from the fact that the puerperal death rate per 1,000 live births in this country is higher than that of most civilized nations and is virtually double that of Denmark, France, Italy, the Netherlands, Norway, or Sweden.

This volume was published as a limited edition. Copies have been presented to a select list of libraries and specialists in public health and allied fields.

HOME AND SCHOOL COOPERATION FOR THE HEALTH OF SCHOOL CHILDREN; a report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, with the cooperation of the National Congress of Parents and Teachers. National Education Association, 1201 Sixteenth St., Washington, 1937. 32 pp. 20 cents.

This report emphasizes the health of the whole child as the most important goal of the intelligent and socially minded community and indicates briefly the principles and practices which may guide parents and educators in effective cooperative effort toward the attainment of their common goal, optimum health for all school children.

Among the topics considered are physical education, sex education, safety education, and parent education. Under "Protection Against Strain," homework and extra-curricular activities are discussed.

CHILD LABOR

CHILD-LABOR TRENDS OF A DECADE[1]

Fifty-eight percent of the total population of the United States was included by the end of 1936 in the area from which the Children's Bureau receives regular reports of first employment certificates issued for children. These employment-certificate figures show the number of children in these areas legally leaving school for work for the first time in occupations for which employment certificates are required in the State where they live. They do not show by any means the total number of children employed in the United States.[2] Nevertheless, they constitute the best available annual index of trends in child employment.

The figures for the decade 1927 through 1936 are especially significant in view of the extreme variations in business conditions, general employment, and legislative standards affecting child employment during the period.

For children 14 and 15 years of age, the figures received from 33 cities of 100,000 or more population reporting for each year of the decade showed that 55,450 first regular employment certificates were issued in 1927. A slight decrease in 1926 was followed by an upswing paralleling the business boom in 1929. Analysis of monthly reports submitted by certain States and cities shows that in many localities child employment began to decline again as early as August 1929. This decline was accentuated during the depression years of 1930, 1931, and 1932.

In 1933, with the adoption under the National Industrial Recovery Act of national child-labor standards higher than most of the State standards, the trend of child employment for the first time diverged from the general economic trend. In the face of a sharp increase in general factory employment, the number of first regular employment certificates issued in these 33 representative cities, which had fallen to 23,393 in 1932, continued to fall. In 1933 it was 14,933 and in 1934, the only entire calendar year when the child-labor provisions of the NRA codes were in operation, the number of employment certificates issued in these cities fell to 4,737.

In order to show clearly the effect on child employment of the removal of national child-labor standards, following the invalidation of the NRA codes in May 1935, the figures for the post-NRA year, from June 1, 1935, to May 31, 1936, are preferable to those of the calendar year 1935.

TABLE 1.—NUMBER, RATE, AND PERCENT OF CHANGE—CHILDREN 14 AND 15 YEARS OF AGE FOR WHOM EMPLOYMENT CERTIFICATES WERE ISSUED, 1927 TO 1934 AND POST-NRA YEAR[a]

Year	Children 14 and 15 years of age for whom first regular employment certificates were issued		
	Number[b]	Number per 10,000 children of these ages	Percent of change in rate as compared with previous year
1927-----	55,450	920	----------
1928-----	52,351	844	- 8.3
1929-----	55,858	876	+ 3.8
1930-----	39,568	605	- 30.9
1931-----	30,428	456	- 24.6
1932-----	23,393	344	- 24.6
1933-----	14,933	222	- 35.5
1934-----	4,737	70	- 68.5
Post-NRA year[c]--	13,579	202	+188.6

[a] This table includes figures from 33 cities with 100,000 or more population (1930 census) reporting to the Children's Bureau each year of the period: Atlanta, Baltimore, Buffalo, Chattanooga, Chicago, Denver, Detroit, Fort Wayne, Grand Rapids, Indianapolis, Kansas City (Kans.), Knoxville, Los Angeles, Louisville, Lowell, Lynn, Minneapolis, Nashville, New York, Oakland, Omaha, Peoria, Providence, Rochester (N.Y.), St. Paul, San Francisco, Somerville (Mass.), South Bend, Springfield (Mass.), Washington (D. C.), Wichita, Wilmington (Del.), and Yonkers.

[b] Figures for Detroit, Grand Rapids, and Providence are for 15-year-old children; laws do not permit issuance of certificates for 14-year-old children.

[c] June 1935-May 1936.

In this post-NRA year the number of certificates issued in the 33 cities represented in table 1

[1] A more comprehensive report, including tables showing employment certificates issued by States and cities reporting to the Children's Bureau, is given in "Trend of Child Labor, 1927 to 1936," by Ella Arvilla Merritt, *Monthly Labor Review*, December 1937. Reprints of this article are available from the Children's Bureau while the supply lasts.

[2] These statistics do not include children employed in occupations for which employment certificates are not required (such as agriculture and domestic service in most States, and street trades in many States), nor children employed illegally; nor do the figures for any specified year show the number of children then working on certificates previously obtained.

rose to 13,579, an increase of 189 percent as compared with 1934. In the calendar year 1936, although in the latter part of that year New York and Rhode Island adopted a 16-year minimum-age standard, a total of 21,910 first regular employment certificates were issued in all the States and cities that reported to the Children's Bureau.[3]

Effectiveness of Legislative Restrictions

The direct result of the adoption of a 16-year minimum age for employment in most industries on a national basis under the NRA codes, as has been shown, was a drastic curtailment in the employment of children 14 and 15 years of age while the codes were in operation.

An indirect result of this national restriction on child labor was the stimulation of State legislation. Since 1932 a basic 16-year minimum age for employment has been established in six States in the reporting area: Wisconsin and Utah, in 1933; Connecticut and Pennsylvania, in 1935; and Rhode Island and New York, in 1936. In the last two States there was a decrease of 94 percent in the number of children going to work in the last 6 months of 1936 as compared with the last 6 months of 1935. In areas where the minimum age for employment was not raised, however, a comparison of the number of employment certificates issued in the same two periods shows an increase of almost 50 percent.

Employment of Minors 16 and 17 Years of Age

So far the employment of children 14 and 15 years of age only has been considered. To complete the picture it is important to consider also employment trends among minors 16 and 17 years of age, whose employment has remained for the most part unrestricted by legislation except in especially hazardous occupations. Employment-certificate information is less comprehensive for this group than for the younger children, because 16- and 17-year-old minors are not so generally required to obtain certificates before going to work. Figures for 18 cities that reported each year during the decade 1927-36 are available, however, and are shown in table 2.

At all times the trend of employment among 16- and 17-year-old minors, where legislative restriction was not a factor of importance, followed the general trend of business conditions. In 1933 and 1934, when under the operation of the NRA codes employment of younger children was lowest, these older boys and girls went to work in increasing numbers, and this increase continued, although less markedly, in 1935 and 1936.

TABLE 2.—NUMBER, RATE, AND PERCENT OF CHANGE—MINORS 16 AND 17 YEARS OF AGE FOR WHOM EMPLOYMENT CERTIFICATES WERE ISSUED, 1927-36[a]

Year	Minors 16 and 17 years of age for whom first regular employment certificates were issued		
	Number[b]	Number per 10,000 children of these ages	Percent of change in rate as compared with previous year
1927-----	28,893	1,362	----------
1928-----	30,585	1,412	+3.7
1929-----	36,453	1,740	+23.2
1930-----	27,793	1,234	-29.1
1931-----	23,403	1,022	-17.2
1932-----	19,972	872	-14.7
1933-----	21,977	952	+9.2
1934-----	26,754	1,159	+21.7
1935-----	27,100	1,174	+1.3
1936-----	[c]26,454	1,232	+4.9

[a] This table includes figures from 18 cities of 50,000 or more population (1930 census) reporting to the Children's Bureau each year of the period: Buffalo, Cincinnati, Columbus, Dayton, Grand Rapids, Hamtramck, Kalamazoo, Milwaukee, New Orleans, New York, Niagara Falls, Rochester, Saginaw, San Francisco, Springfield (Ohio), Toledo, Yonkers, and Youngstown.

[b] Figures for cities in Wisconsin and New York are for 16-year-old minors; laws did not require issuance of certificates for minors over 16 until September 1935 in Wisconsin and September 1936 in New York State. Figures for New Orleans are for girls only.

[c] Figures for Hamtramck are for 16-year-old minors only. Figures for San Francisco and the District of Columbia include certificates issued for work outside school hours and during vacation.

In 1936, in all the States and cities reporting to the Children's Bureau, a total of 96,258 minors 16 and 17 years of age were certificated for their first regular employment.

Occupational Shifts

A count of the children leaving school for work, however, does not tell the whole story. The kind of work these children find to do has a significance of its own in relation to the general economic milieu and in relation to the later industrial life of the children themselves. Analysis of the employment-certificate statistics shows that there is a characteristic occupational distribution for each age group and that this varies

[3] 18 States and 50 cities of 25,000-50,000 population and 78 cities of 50,000 or more population in 21 other States.

significantly from year to year. It is affected no doubt by trends in child-labor legislation. It also shows a relationship with economic trends and employment opportunities.

In areas reporting occupations every year from 1929 to 1936 almost half (49 percent) of the 32,000 14- and 15-year-old children certificated in 1929 entered manufacturing and mechanical occupations. This percentage fell to 36 in 1932, when factory jobs were scarce because of the depression. In 1934, when the 16-year minimum-age standard of the NRA codes was in effect, children under 16 practically disappeared from the factories. Only 1 percent of the employment certificates issued for children in that year were for manufacturing and mechanical occupations. In 1935 the stream of child labor began to turn back toward the factory, and in 1936, 18 percent of the children for whom certificates were issued in these areas entered manufacturing and mechanical occupations.

In States and cities reporting occupations every year from 1929 to 1936 the percentage of minors 16 and 17 years of age who entered manufacturing and mechanical occupations dropped from 40 percent in 1929 to 28 percent in 1930 and 22 percent in 1931. It never fell so low as the percentage of children under 16, who were barred from factory work under the codes, but hovered around 14 percent during 1934 and 1935, and rose again to nearly 21 percent in 1936.

Most studies of child labor have dealt with the work of young persons in occupations commonly referred to as industrial and commercial; that is, in manufacturing and mechanical occupations, in stores, in messenger and delivery service, in office work, etc. Children going to work in such occupations are uniformly covered in nearly all States by employment-certificate laws; those entering domestic service and farm work, on the other hand, are subject to these laws in some States and exempted in others. Because of the resulting lack of uniformity in the reports of children going into domestic service and agriculture, it is pertinent to examine the relative proportions of children going to work in occupations exclusive of these two categories. In areas reporting occupations in 1936, employment certificates were reported for 9,452 children 14 and 15 and 46,503 children 16 and 17 years of age entering nondomestic and nonagricultural occupations. Of these, one-fifth of the younger children and approximately two-fifths of the older boys and girls entered manufacturing and mechanical occupations. About one-fourth in each age group entered mercantile work. The percentage of children taking up messenger and delivery work was about twice as large for the 14- and 15-year-old boys and girls as for those 16 and 17 years of age (35 percent as compared with 18 percent).

The Employment-Certificate System

The effectiveness of an employment-certificate system depends to a great extent upon the proof of age accepted. Reliable evidence of age is necessary if employment of children under the legal minimum age is to be prevented. The figures for the decade under consideration show an increase in the percentage of children certificated on the basis of birth certificates (which are accepted as the most reliable type of evidence) from 57 percent in 1927 to 67 percent in 1936.

The need for further legislative restrictions on the employment of children under 16 in States which have not yet adopted a 16-year minimum age for industrial employment is shown by the increases in employment certificates issued to children 14 and 15 years of age in these States in 1935 and 1936.

Increasing employment of boys and girls 16 and 17 years of age during the same period indicates the need for further attention to legislation regulating conditions of work for minors. In all States, and especially in States with a 16-year minimum-age law, the protection afforded by an employment-certificate system should be extended to minors 16 and 17 years of age. This not only helps to prevent employment of children under the legal age but also aids in the enforcement of protective laws affecting minors, such as those relating to hours of work and hazardous occupations. Through the employment-certificate system it is possible also to keep in touch with boys and girls entering occupational life and to offer them occupational guidance and counseling, placement service, and health supervision.

Socially Handicapped Children

News and Research Notes

Blue Ridge Institute report on delinquency prevention through community organization

A summary of the Jacksonville study of families of 100 delinquent youths, together with the committee findings of the Blue Ridge Institute (1937) for Southern Social-Work Executives, has been published under the title "Organizing the Community for Delinquency Prevention" (Bulletin No. 93, October 1937, Community Chests and Councils, 155 East 44th St., New York). The children studied include 46 Negro boys, 31 white boys, and 23 white girls committed from Jacksonville to State schools. Eighty-three of the children were 12 to 16 years of age.

The purpose of the study was "to determine whether the community could, in any manner, modify or improve its services so as to effect a reduction in the rate of juvenile delinquency," and also how the services of the county social agencies "might be coordinated to focus upon the problem of juvenile delinquency." A provisional report of a factual nature was prepared by the Jacksonville Council of Social Agencies (Juvenile Delinquency in Duval County, 1937; 97 pp.) and was used as a basis for study and discussion by four committees at the 1937 session of the Blue Ridge Institute. The four committees of the Institute were concerned with case work and relief; health; recreation and group work; and courts, probation, and parole.

Practically all the families in the study were in serious economic straits. Three-fifths of them were trying to live on an income below that set by the Federal Emergency Relief Administration for meeting minimum needs ($10.67 per week for a white family of three; $8.33 for a colored family of three).

In only 14 cases were the parents of the children married and living together. In nearly half of the families there was an official criminal record for one or more members. Among health problems of these families were found 28 cases of syphilis and 3 of gonorrhea; 11 cases of undernourishment and anemia; 6 cases of severe cardiac disorders; and 5 cases of tuberculosis. Housing was found to be inadequate, particularly among the Negro families.

Fully 88 percent of the families at one time or another had been under the care of one or more social agencies in Jacksonville. In 12 of the families, the first agency contact was made before the child was 5 years of age, and in 46 of the families when the child was less than 10 years of age. Relief and medical aid were the most frequent services rendered. Only 16 cases had received case-work services during the first year of contact.

The case-work committee of the Institute, on the basis of the data on these 100 children and their families, found that "the delinquent children's group is an indicator of a group of families in which there exists a wide range of problems and a high probability of serious outcome of the sort toward which the social services of the community should be directed."

All four committees agreed on the need for additional community services such as general family case-work service, children's case-work service, facilities for foster-home care and for care of Negro feeble-minded children, medical social service, and the extension of public-recreation, group-work, and camping facilities. Recommendations were also made looking toward the coordination of services of existing agencies.

Proceedings of National Conference of Jewish Social Welfare

The *Jewish Social Service Quarterly* for September 1937 (vol. 14, no. 1) contains the proceedings of the 1937 Indianapolis sessions of the National Conference of Jewish Social Welfare. This includes papers on institutional child care by Jacob Kepecs and by Jules Bank and Frank J. Cohen, and on foster-home child care by Helen Baum and Henrietta L. Gordon.

National Recreation Association honors Joseph Lee

The December 1937 issue of *Recreation* is devoted to articles in tribute to the life and work of Joseph Lee, who served as president and leader of the National Recreation Association from 1910 until his death in July 1937.

BOOK AND PERIODICAL NOTES

A. Social-Work Techniques

WHAT SOCIAL WORKERS SHOULD KNOW ABOUT ILLNESS AND PHYSICAL HANDICAP. Family Welfare Association of America, 130 East 22d St., New York, 1937. 78 pp. 60 cents.

The papers in this pamphlet are summaries of lectures given under the auspices of the Westchester County Council of Social Agencies to acquaint non-medical social workers with the salient medical and social facts about the most common diseases. The lectures, given by physicians, are not technical in nature but emphasize the part the patient's attitude and environment play in the progress and treatment of his disease. Each physician's paper is followed by an amplification of the social aspects of the illness, presented by a medical social worker. One chapter deals with pediatrics and one treats the question of medical ethics, particularly the confidential nature of medical and social history and the resulting necessity for understanding thoroughly the doctor, patient, and social-worker relationships.

SOCIAL WORKERS AND THE FIGHT ON SYPHILIS, by Mazie F. Rappaport. *Councillor* (Baltimore Council of Social Agencies), vol. 2, no. 2 (June 1937), pp. 15-18.

This article points out that the social worker should try to develop a sense of social responsibility in the syphilis patient, and should follow up each case and help the patient overcome resistance to treatment.

B. Delinquency and Its Prevention

LATER CRIMINAL CAREERS, by Sheldon Glueck and Eleanor Glueck. Commonwealth Fund, New York, 1937. 403 pp. $3.

This is the first of several studies with which the authors hope to follow up their earlier study, "500 Criminal Careers," published in 1930. It reports an investigation into the later careers of 454 survivors of this group of young adult male offenders who had been committed to the Massachusetts Reformatory. With the financial aid of the Milton Fund of Harvard University and later of the Commonwealth Fund of New York, the authors undertook to re-study these men over a second 5-year period that had elapsed since their release in an effort to determine what changes occurred in their behavior.

Because the earlier study indicated that, with the passage of time, certain improvements occurred in the behavior of the men, the authors sought to discover whether the further passage of time brought about still further improvement. They believed that the answers to this and to related questions should be of significance in the solution of practical problems such as the desirable length of the "indeterminate sentence," and the length of time during which offenders of different types should be removed from the community.

During the second 5-year period 32.1 percent of the men were clearly nondelinquent as compared with 21.5 percent who were nondelinquent during the first period. General improvement, greater in some respects than in others, was noted in the second 5-year period "in all the major aspects of the lives of these men--in their family relationships, in the assumption of their economic responsibilities, in their industrial adjustments, in their use of leisure, and, most important, in the character and extent of their delinquent behavior."

Although a close relationship was found to exist between nondelinquency during the 10-year span and the favorable aspects of other major factors, the authors believed these findings did not justify any conclusion other than that good family relationships, the assumption of economic responsibilities, successful industrial adjustments, and wise use of leisure *accompany* nondelinquency. Comparing the characteristics of the men who reformed and those who continued to be delinquent they found that there was little difference between the characteristics and conditions of the two groups of men prior to their commitment. The few significant differences were in favor of those who reformed. After the expiration of their reformatory sentences, however, the differences between the groups became much greater and increased as time passed.

Examination of the 63 factors studied revealed that only within the factor of "aging" or maturation was significant explanation to be found for the increasing trend away from delinquent conduct. The authors found that "with two or three exceptions, improvement in all respects progresses and accumulates to about the thirty-sixth year of

age, after which a marked decline sets in," which led them to believe it probable that those offenders who have not reformed by their thirty-sixth year are much less likely to do so thereafter.

It appeared "that the most marked difference between the reformed and unreformed lies in the factor of mental or emotional difficulties, as evidenced by the finding that only 15.2 percent of those who reformed were burdened with some psychiatric condition as opposed to 89.9 percent of those who continued to be delinquent or criminal." The authors therefore conclude, "it can safely be said that the failure to reform despite the aging process is in great measure chargeable to the influence of abnormal mental condition."

As a result of their study the authors ask whether it may not be that certain physical and psychologic changes occurring for a more or less definite span of time preceding and following the thirty-fifth year tend to explain the occurrence and accumulation of reform up to that age as well as the marked drop in its incidence thereafter, and discuss the possibility of developing and applying artificial substitutes for the maturation process through improvement in the existing sentencing, supervisory, and treatment practices.

In considering the effectiveness of delinquency-prevention programs, the authors infer that the children who respond favorably are likely to be those who were not delinquently inclined in the first place, and that even in the case of offenders who, because of mental taint, persist in wrongdoing, these programs may have value in reducing opportunities for antisocial expression. They conclude that "careful investigations into the traits of 'problem children,' and 'predelinquents' correlated with their subsequent evolution into criminals or noncriminals, are a crying need of the entire field of criminology.

A.S.N.

REPORT ON VICTORIAN CHILDREN'S COURTS FOR THE YEAR 1936. Children's Court Office, Titles Office, Melbourne, Australia, 1937. 15 pp.

In addition to statistics reported by children's courts for the year 1936, this report contains a summary of cases coming before these courts during the period 1927-36.

The Children's Bureau *does not distribute* the publications to which reference is made in THE CHILD except those issued by the Bureau itself. Please write to the publisher or agency mentioned for all others.

OF CURRENT INTEREST

MOTION PICTURE ON "THE BIRTH OF A BABY"

An educational motion picture, "The Birth of a Baby," has been prepared under the direction of a subcommittee of the American Committee on Maternal Welfare, with Dr. Fred L. Adair as chairman. The object of the picture is to educate the public to the need for maternal care and the value of the physician's services.

The film was first shown to physicians attending the Atlantic City session of the American Medical Association. The plan is to show this picture before each State medical society and, in the larger cities, before the city or county medical society. After approval of the society has been obtained it will be possible to exhibit the film to groups of local physicians and, with whatever age restrictions may be recommended by the local medical society, to the public.

Delegates to the Conference on Better Care for Mothers and Babies called by the Children's Bureau for January 17-18 will have an opportunity to view "The Birth of a Baby." Inquiries in regard to this film should be addressed to Dr. Fred L. Adair, Chairman, The American Committee on Maternal Welfare, Inc., University of Chicago, Chicago, Ill.

CONFERENCE CALENDAR

Jan. 16-20	American Academy of Orthopedic Surgeons. First West-Coast meeting, Hotel Biltmore, Los Angeles, Calif. Secretary: Dr. Carl E. Badgley, 1313 East Ann St., Ann Arbor, Mich.
Jan. 29-31	Child-Labor Day. Information and materials (25 cents) from National Child Labor Committee, 419 Fourth Ave., New York.
Feb. 2	National Social-Hygiene Day. Information from American Social Hygiene Association, 50 West 50th St., New York.
Feb. 24-26	American Orthopsychiatric Association. Fifteenth annual meeting, Stevens Hotel, Chicago, Ill. Secretary: Dr. Norvelle C. LaMar, 210 East 68th St., New York.
Apr. 19-23	Association for Childhood Education. Forty-fifth annual convention, Netherland Plaza Hotel, Cincinnati, Ohio. Information: Mary E. Leeper, Executive Secretary, Association for Childhood Education, 1201 Sixteenth St., NW., Washington, D.C.

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CONFERENCE ON BETTER CARE FOR MOTHERS AND BABIES

January 17 and 18, 1938, Washington, D.C.
Called by the Chief of the Children's Bureau, United States Department of Labor

PROGRAM

Monday, January 17, 1938

Morning session

Presiding: KATHARINE F. LENROOT, Chief of the Children's Bureau

Address of welcome
THE HON. FRANCES PERKINS, Secretary of Labor

The Need Today

Maternal and Child Health in Relation to the Health of All the People
THOMAS PARRAN, JR., M.D., Surgeon General, United States Public Health Service

What Is Good Care for Mothers and Babies?
JENNINGS LITZENBERG, M.D., Professor of Obstetrics and Gynecology, University of Minnesota Medical School
HORTON CASPARIS, M.D., Professor of Pediatrics, Vanderbilt University School of Medicine

What Is the Need Today?
MARTHA M. ELIOT, M.D., Assistant Chief of the Children's Bureau

Afternoon session

Presiding: MRS. J.K. PETTENGILL

What Is Involved In Extending Good Care to All Mothers and Babies?

Economic Resources and Ability To Secure Good Care
MORDECAI EZEKIEL, PH.D., Economic Adviser to the Secretary of Agriculture
A.F. HINRICHS, PH.D., Chief Economist, Bureau of Labor Statistics, United States Department of Labor

Professional Resources and Ability To Provide Good Care
M. EDWARD DAVIS, M.D., Associate Professor of Obstetrics and Gynecology, University of Chicago School of Medicine

Community Resources and Ability To Organize for Good Care
FELIX J. UNDERWOOD, M.D., Executive Officer, Mississippi State Board of Health

The Challenge to the Citizen
THE HON. FIORELLA H. LAGUARDIA, Mayor of New York City

Evening session

Presiding: MRS. J.K. PETTENGILL

Forum: How the Challenge May Be Met

Questions for discussion

To what extent is the public aware of the problem?

How can public awareness be stimulated?

What methods of coordinating citizen, professional, and official effort are most practical?

What provision can be made for continuing the work of the conference?

* * * * *

Tuesday, January 18, 1938

Morning session
(East room of the White House)

Presiding: KATHARINE F. LENROOT

Address
MRS. FRANKLIN D. ROOSEVELT

Symposium: What Is Being Done Today—What Can Be Done Tomorrow?

Participants

MARTHA M. ELIOT, M.D., leader

B.F. AUSTIN, M.D., Director, Bureau of Hygiene and Nursing, Alabama Department of Public Health

VIRGINIA C. BAILEY, R.N., Public Health Nurse, Enosburg Health Unit, Vermont

JESSIE M. BIERMAN, M.D., Director, Child Welfare Division, Montana State Board of Health

RUBY BROUILLETTE, R.N., Public Health Nurse, Washington County, Iowa

BEATRICE E. TUCKER, M.D., Medical Director, Chicago Maternity Center

PHILIP F. WILLIAMS, M.D., Assistant Professor of Obstetrics, University of Pennsylvania School of Medicine

Address: The Goal We Seek
JOSEPHINE ROCHE

Afternoon session

Presiding: KATHARINE F. LENROOT

Summary of conference proceedings by the chairman

Reports of special committees

Report of committee on findings

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